STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505406	A. BUILDING _____ B. WING _____	C 10/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CARE CENTER	855 AARON DRIVE LYNDEN, WA 98264

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Abbreviated Survey conducted at Christian Health Care Center on 10/2/13. A sample of 7 residents was selected from a census of 137. The sample included 6 current residents and 1 discharged resident.

The following complaints were investigated as part of this survey:

2870762
2870034

The survey was conducted by:

[redacted] R.N., M.S.N.

The survey team was from:
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit B
3906 172nd Street NE, Suite 100
Arlington, WA 98223
Telephone: (360) 651-6850
FAX: (360) 651-6940

Residential Care Services — Date 10/15/13

OCT 28 2013
ADSA/RCS
Region 3

[illegible] 3 2013
ADSA/RCS
Region 3

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: C. L Reb-El Bara — TITLE: Administrator — (X6) DATE: 10/23/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow standards of practice for 1 of 7 sampled residents (1). Failure to follow physician's orders for wound treatment may have placed the resident at risk for a delay in wound healing. Findings include: RESIDENT 1: Resident's 1 physician's order, dated 9/24/13, directed Licensed Nurses (LNs) to apply a transparent ([redacted] dressing to her open wound on the [redacted] arm. The wound, which was orginally sustained on [redacted] as a skin tear during a [redacted] transfer, measured 1.25 cm (centimeters) in diameter at the time of the incident. Review of the Treatment Record (TAR) for October 2013, revealed LNs had initialed the TAR indicating the tegaderm dressing had either been applied or checked as in place on her left arm skin tear. The TAR for September 2013 revealed the tegaderm was applied starting 9/23/13 and checked or reapplied twice a day. On 10/2/13 at 2:50 p.m., LN E was observed during a dressing change on the skin tear. The wound on the resident's [redacted] arm did not	F 281	Dressings and treatments for Resident 1 were discontinued as of 10/16/13 and as of 10/24/13 the skin tear has resolved. For residents in similar situations, all physician orders for residents with a dressing were reviewed and the residents were observed to ensure that the dressings were applied per the physician's order. To ensure the problem does not recur, all nurses were in-serviced on following physician's orders. To make sure solutions are sustained the nurse managers will randomly audit and observe residents with physician orders for dressings to make sure the ordered dressing is being applied correctly. Audit findings will be reported at facility Quality Assurance Meeting. DNS/Administrator responsible to ensure correction.	11/11/13

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F 281	Continued From page 2 have a [redacted] in place but rather a telfa dressing that was secured with tube gauze. LN E verified the telfa dressing was not the correct dressing as ordered by the physician on 9/24/13. Further review of the physician's orders revealed the use of this nonadhesive dressing was discontinued on 9/24/13, when the [redacted] was initiated.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate assistance for one of 7 sampled residents reviewed for accidents (1). Failure to follow the plan of care when transferring Resident 1 resulted in a skin tear to her left upper arm. Findings include: The facility's policy on "Transferring Residents Using Mechanical Lift" informed staff that the residents who required a mechanical lift to ensure a safe transfers will be noted on the resident's Plan of Care. The policy guide for standards of care stated the plan of care would provide	F 323		

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F 323	Continued From page 3 direction for each resident's care and Nursing Assistants (NACs) are responsible for following the Plan of Care. RESIDENT 1: Resident 1 was admitted to the facility on 2011 with diagnoses of [redacted] The Minimum Data Set (MDS) assessment, dated 6/20/13, revealed the resident required 2 person assist with transfers and bedmobility. The resident's Care Guide directed staff to transfer the resident with a hoyer (mechanical) lift with 2 person assist and to ensure the resident wore long sleeves during transfers due to her fragile skin. The Plan of Care for skin integrity informed staff to be gentle with transfer and "ensure arms are not bumped or scraped". A nursing note, dated 9/2/13, documented the resident sustained a skin tear during a hoyer transfer. The skin tear was 1.25 centimeters (cm) in size and in a circular shape. The Licensed Nurse (LN) cleansed the wound with saline and applied steri strips. The Treatment Sheet for September 2013 revealed LNs were to monitor the skin tear until healed, starting on 9/2/13. The facility's investigative report, dated 9/1/13, revealed Resident 1's skin was pinched during a hoyer lift transfer which resulted in a skin tear to her upper left arm. The investigation concluded the nursing assistant (NAC) did not follow the plan of care and had transferred the resident by herself using the hoyer lift. Review of the facility's inservice reports revealed a mandatory inservice was given to staff regarding the directive that all residents care	F 323	Resident 1 is now consistently transferred per plan of care. To protect residents in similar situations transfers for all residents whose plan of care directs two person Hoyer lift transfers have been monitored to assure plan of care compliance. To ensure that this problem does not recur, the NAC transferring Resident 1 is no longer employed by CHCC. All nursing staff has been in-serviced regarding the facility policy related to following Plan of Care for transfers with the Hoyer Lift. Random observations/resident interviews of Hoyer Lift transfers by the team leaders and unit coordinators will be completed on a regular basis. Results of these observations and/or interviews will be reported on at the facility QA meeting. DNS/Administrator is responsible for correction.	11/11/13

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F 323	Continued From page 4 plans were to be followed, and NACs were responsible for reading and following the Plan of Care. The NAC who had transferred Resident 1 by herself using a hoyer lift transfer had attended the inservice on 8/27/13. On 10/2/13 at 9:50 a.m., Resident 1 was interviewed. When asked if 2 people assisted with her hoyer lifts, she stated "usually". On 10/2/13 at 3:50 p.m., the Director of Nursing (DNS) verified the NAC did not provide the needed assistance the resident required to safely transfer her.	F 323		